It obviously means the adoption of a new syringe if we take up the same system.

I should like to make the following suggestions: (1) Scrap all 20 unit/ml insulin preparations. (2) Retain 40 and 80 unit/ml strengths. (3) Supply new syringes clearly stamped "40" or "80" in heavy black type and calibrated accordingly. A slip could be inserted with each syringe and in each packet of insulin reading "use only 40 syringe with 40 bottle; "use only 80 syringe with 80 bottle."

These measures would, I am sure, rule out most errors.—I am, etc.,

E. R. SPEARING

Mayday Hospital,
Thornton Heath, Surrey

Fees for Cremation Certificates

SIR,—A fee of up to £4 and even more is now being charged for the completion of both part B and part C of cremation forms. Some doctors feel that this fee is an unprofessional and distasteful extortion from their patients' families at a time of stress and grief.

In general practice the position is often different, but in the majority of deaths occurring in hospitals it can be argued that the doctors do not have to make any special journeys or examinations in order to fill in the forms and do not themselves incur expenses. The pursuit of cremation fees has resulted in embarrassing procedures. In at least one hospital for some time one doctor exercised the prerogative of signing the second part of all the cremation forms and collecting the fees, perhaps at a cut-price rate. A popular practice in hospitals is for the money from cremation fees to be paid into a mess fund so that no junior doctor benefits financially from working in a ward where deaths are frequent. There has also been a tendency for some hospital authorities to charge a smaller amount in the cases of hospital contract funerals, although there are more frequent cases in which family poverty might justify a reduced fee.

Opinion within the medical profession is probably divided on this subject and it is possible that more doctors condemn these fees than might at first be suspected. They accept the money, feeling perhaps that they themselves have to make to others many payments of which they disapprove.—I am, etc.,

D. A. SPENCER

Meanwood Park Hospital,
Leeds

Side Effects of Lithium Carbonate

SIR,—I have under my care a very intelligent physicist, aged 50, who has suffered from recurrent bouts of depression. At his request and with my agreement he was given lithium carbonate 250 mg thrice daily. He complained of certain side effects and his own account of these is as follows:

"A few days after starting to take lithium carbonate I noticed a strange and unpleasant taste associated with certain foods. The first to be affected were butter and celery; both had a strong flavour quite unlike anything else I have experienced. The 'new' flavour seemed superimposed on the original taste, and was the same for both

these foods. Cooked celery also had a strong associated smell, which I found most unpleasant; other vegetables tasted and smelt perfectly normal. I stopped taking butter and changed to margarine. After about two weeks, cream and mild cheese developed the same taste, and then margarine. Other food (for example, milk, eggs, and apples) remained normal, while some vegetables (such as onions) tasted slightly unpleasant. Food generally seemed less appetizing. Even a trace of butter (for example, in cakes) rendered them very unpalatable. After stopping taking the lithium, taste returned to normal within two days, and food again became appetizing."

I have not seen descriptions of these particular symptoms before and should be interested to know whether they have previously been noted.—I am, etc.,

J. ELWES DUFFIELD

Littlemore Hospital,
Oxford

Nutritional Value of School Meals

SIR,—Contrary to the implication in the letter from Susan M. and Dr. M. C. Bateson (27 January, p. 234) in our survey (23 December, p. 697) the food brought from home and bought elsewhere compared unfavourably with the school meal.

As we reported, the survey method employed in our study was the use of a questionnaire. All children were asked to state in detail exactly what they had selected and how much they had eaten during the lunch break. The senior schoolchildren proved able to give an acceptable record of their consumption of the school meal and food obtained elsewhere. Representative samples of all the foods the children consumed were collected and weighed. This information, together with all data collected on consumption, was converted into terms of nutrient content.

The direct weighing method of food offered and food wasted from all sources is the only one which gives an absolutely precise measure of food intake. However, within the framework of our study and the fact that there is good evidence¹ to show that the method employed compares well with precise weighing methods, we believe this study reflects the nutritional value of the mid-day meals of senior schoolchildren.—We are, etc.,

D. P. RICHARDSON
M. LAWSON

Queen Elizabeth College,
University of London

¹ Samuelson, G., *Acta Paediatrica Scandinavica*, 1971. Supplement 214.

Anomalies in Tendon Reflexes

SIR,—I have recently been investigating tendon reflexes, using needle electrode myography and a reflex hammer with a triggering mechanism for the oscilloscope. The maximum delay on the tendon hammer trace is less than one microsecond as measured on a monitoring oscilloscope.

I have noted that I have been recording action potentials, as elicited as a reflex, with the characteristics of polyphasicity and temporal dispersion, as one finds in com-

pression neuropathies, in addition to finding absolute delays on latency. I would be interested to hear from other workers who may have observed this phenomena, and I would be grateful if they will contact me.

V. B. WHITTAKER

Royal Herbert Hospital,
Woolwich,
London S.E.18

The Pill and Venereal Disease

SIR,—Some of us who have spent years in controlling infectious diseases feel that public discussion has been focused too much on the prevention of unwanted pregnancies and not nearly enough on the alarming increase in venereal disease. This leads one to the simple question of what form of preventative should be made available to applicants under any extension of the present method of issue.

In my opinion, the contraceptive pill should be prescribed virtually only for married women, who are less likely to be subjected to the dangers of promiscuity than are sexually enthusiastic single people. For the unmarried it would seem that the rational procedure would be to educate them in the careful use of the sheath, which alone keeps the sexual organs from actual contact. I think this might be safer for the male than copper intrauterine devices.—I am, etc.,

GUY BOUSFIELD

Broadbridge Heath,
Sussex

Infantile Mumps

SIR,—During the current epidemic of mumps I have seen a baby of 11 months with the typical picture of mumps complicated by bilateral epididymo-orchitis.

Is this a record?—I am, etc.,

B. S. MILNER

Edenbridge, Kent

Chondromalacia Patellae

SIR,—In your leading article (15 April 1972, p. 123) on chondromalacia patellae reference was made to our work on the bony changes in this condition,¹ with the comment that further clinical information would be of interest.

All the patients investigated were referred by orthopaedic surgeons or rheumatologists with a diagnosis of chondromalacia patellae. Only patients fulfilling stipulated criteria,² which included those outlined in your article, were accepted. The patients subjected to patellectomy had a history ranging from eight to 27 months, with a mean of 15 months. Those investigated with 87m-Sr bone scans had histories ranging from six to 20 months with a mean of 12 months.

Since the preliminary report we have investigated a further 24 patients with bone scans and six patellae after patellectomy. All have had changes identical with those already described. Cartilaginous changes were found in only 12 of the total of 17 patellae examined, which is similar to the incidence of such changes found in non-symptomatic knees at necropsy,³ while the changes de-

scribed in the subchondral osseous plate and trabecular bone¹ were present in all 17 patellae.

Although the treatment is problematical, promising results have been obtained with graduated quadriceps exercises and intra-muscular nandrolone propionate.—We are, etc.,

J. DARRACOTT

McMaster University,
Hamilton, Ontario, Canada

B. VERNON-ROBERTS

The London Hospital,
London E.1

¹ Darracott, J., and Vernon-Roberts, B., *Rheumatology and Physical Medicine*, 1971, 11, 175.

² Robinson, A. R., and Darracott, J., *Annals of Physical Medicine*, 1970, 10, 286.

³ Owre, A., *Acta Chirurgica Scandinavica*, 1936, 77, Supplement 41.

Screening for Cervical Carcinoma

SIR,—I cannot help but feel that the Department of Health and Social Security is being hypocritical about the screening of women for carcinoma in situ of the cervix.

At the Council meeting of 31 January Dr. J. C. Cameron announced that agreement had been reached with the Department regarding an extension of "public policy" in that payment would now be made for two further groups of women: (1) women over 35 on the quinquennial anniversary of their birthday, irrespective of whether they had been screened in the intervening period or not; and (2) women under 35 who had had three or more pregnancies. Dr. Cameron explained that the latter group had been included on the grounds that women who led active sexual lives were at greater risk than the nulliparous (*Supplement*, 10 February, p. 41). If this is true, while one applauds any move to extend the scope of screening for carcinoma of the cervix, one cannot condone illogical thought. The fact that a woman under 35 has had three or more pregnancies just does not mean that she leads a more active sex life than the one with fewer or no children. Someone must really whisper the facts of life in the ear of the D.H.S.S.

In 1968 I drew attention to the high incidence of carcinoma in situ in young women.¹ This has been noted by most other observers too and is emphasized by Dr. E. Ann Tait in her letter (3 February, p. 296). In my own survey of 700 women at risk there were 14 with positive smears; six of these were under 35 years of age and included two girls aged 17 and others aged 20, 22, 26, and 29 years respectively.

If the Department is reluctant to extend "public policy" to screening of all women irrespective of age because of economic considerations it should be honest enough to declare this. The medical profession must reject pseudoscientific theories and condemn the failure of the Department to take heed of well-documented clinical observations of many workers in this field.

RALPH A. A. R. LAWRENCE

Leabrooks, Derby

¹ Lawrence, R. A. A. R., *Journal of the Royal College of General Practitioners*, 1968, 16, 379.

Management of the N.H.S.

SIR,—Wise patients normally follow their doctors' advice. Management in the N.H.S. are responsible for seeing that the patients

in their care receive good medical treatment, and if wise will want to be guided by their medical staff in matters which directly or indirectly affect patients' medical welfare. It is open to doubt whether this has been fully appreciated in the imminent reorganization of the Service. I would like to draw attention to one facet of the problem.

The object of the hospital and domiciliary service is health care, and this is provided primarily by clinicians. Clinicians are responsible, morally and legally, for the care of patients. They know most intimately their needs and the investigatory and therapeutic requirements to meet these needs. One would have expected, therefore, that clinicians would have been given a large say in management, at least at district level where the work of the Service will largely be carried out. Management, however, is to be in the hands of a district management team consisting of four administrators assisted by one general practitioner representing anything from two to 300 G.P.s and one consultant representing anything from 50 to 100 consultants. Between them these doctors will be responsible for the care of tens of thousands of patients annually. The team is to be concerned not only with the day-to-day management of their district but also with the continuous forward planning of medical services therein. It is hard to believe, with the complexity of modern medicine, that anyone could have thought of this as a satisfactory arrangement, likely to result in an efficient service or to engage the enthusiastic support of clinicians. To suggest such a minimal role for the 300-400 doctors who will be actually responsible for the remedial care of perhaps a quarter of a million potential patients is surely a trifle absurd.

While the broad outline of the proposed new management structure cannot be changed, much detail is still open to discussion. Perhaps the proposed composition of the district management team is no more than a negotiating position. Certainly it is up to consultants and G.P.s in the districts to do their best to get the composition altered to something which more nearly corresponds to the realities of patient care.—I am, etc.,

DAVID FERRIMAN

London N.W.5

Ten-session Consultant Contract

SIR,—We should like to add our voices to the growing volume of disagreement with the proposed new consultant contract.

We accept that there is a problem to be solved, in that consultant manpower is unequally distributed in Britain and some consultants work much longer hours than others. The acceptance of additional N.H.S. commitments (such as abortions and vasectomy) without any increase of staffing compounds the problem. The solution proposed in the new 10-session contract is to specify the number of hours for which a consultant must work in order to earn his basic salary and to pay him for additional out-of-hours work. We find this suggestion distasteful. It will involve the profession in an unprofessional approach to the care of patients and will progressively diminish our independence. Who will certify that our extra-duty claims are reasonable? It will not be long before we are "clocking in" and obtaining certi-

ates of attendance from the appropriate duty administrative officer.

The details of the new contract must be settled before it is priced. It appears unlikely that it will result in a significant increase in the total sum available for remuneration of consultants. The basic salary will, therefore, tend to be reduced, and consultants will be in competition with each other for their share of the "overtime" or "extra-duty" moneys. It is a disturbing thought that there will be a financial incentive to postpone urgent work till after normal working hours.

We are equally disturbed by the proposal that even full-time consultants will have the right to see private patients and to retain the fees. Although theoretically private practice after working hours is not incompatible with N.H.S. responsibilities, we believe that in many specialties there is a conflict of interests which will be to the detriment of the Health Service.

We have not yet met any large group of hospital staff who are in favour of the new consultant contract. Certainly in the teaching hospitals (where we work) opinion appears to be overwhelmingly against the features we have commented on. We understand the plight of overworked consultants in understaffed regional hospital, but there must be better ways of helping than those proposed in the 10-session contract. In addition, the new contract would open a gap between N.H.S. staff and their university colleagues, which would weaken the medical schools and hamper improvements in medical education, both undergraduate and postgraduate.—We are, etc.,

I. BOUCHIER

L. BEILIN

J. LORBER

W. GREIG

R. SHANKS

R. LOWE

C. WHITE

Association of University Clinical Academic Staff,
c/o St. George's Hospital Medical School,
London S.W.1

Points from Letters

The Disease of Alcoholism

Dr. J. W. TODD (Farnham, Surrey) writes: Does the view that alcoholism is a disease improve the prospects of recovery? I know of no evidence that it does, and I suspect that it may well have the opposite effect. If the alcoholic is constantly told that he is the victim of a disease, which carries the implication that he is a helpless victim who must be cured by the efforts of others, is he likely to acquire the conviction which is the over-riding prerequisite for recovery—that he must stop drinking for ever?

Contraception and Infertility

Mr. M. BRUDENELL (King's College Hospital, London S.E.) writes: Mr. H. P. Dunn (27 January, p. 237) argues that the proposition that the best prophylactic against postabortion sterility is adequate contraception to prevent unplanned pregnancy is invalid, because as contraceptive advice is disseminated the abortion rate goes up. Surely the point is that the abortion rate goes up only in those not practising contraception. Every doctor in this country dealing with patients requesting abortion is aware how often the unplanned pregnancy results from a lack of contraception.